History Taking: 1

#### **UNIT TERMINAL OBJECTIVE**

3-1 At the completion of this unit, the paramedic student will be able to use the appropriate techniques to obtain a medical history from a patient.

## **COGNITIVE OBJECTIVES**

At the completion of this unit, the paramedic student will be able to:

- 3-1.1 Describe the techniques of history taking. (C-1)
- 3-1.2 Discuss the importance of using open ended questions. (C-1)
- 3-1.3 Describe the use of facilitation, reflection, clarification, empathetic responses, confrontation, and interpretation. (C-1)
- 3-1.4 Differentiate between facilitation, reflection, clarification, sympathetic responses, confrontation, and interpretation. (C-3)
- 3-1.5 Describe the structure and purpose of a health history. (C-1)
- 3-1.6 Describe how to obtain a comprehensive health history. (C-1)
- 3-1.7 List the components of a comprehensive history of an adult patient. (C-1)

#### **AFFECTIVE OBJECTIVES**

At the completion of this unit, the paramedic student will be able to:

- 3-1.8 Demonstrate the importance of empathy when obtaining a health history. (A-1)
- 3-1.9 Demonstrate the importance of confidentiality when obtaining a health history. (A-1)

### **PSYCHOMOTOR OBJECTIVES**

None identified for this unit.

# **DECLARATIVE**

- I. Overview
  - A. Purpose
    - 1. This information is gathered on a patient by patient, case by case basis
  - B. Several parts
    - 1. Specific purpose
    - 2. Together they give structure
  - C. Does not dictate sequence
- II. Content of the patient history
  - A. Date
    - 1. Always important
    - 2. Time may also be a consideration
  - B. Identifying data
    - 1. Age
    - 2. Sex
    - 3. Race
    - 4. Birthplace
    - 5. Occupation
  - C. Source of referral
    - Patient referral
    - 2. Referral by others
  - D. Source of history
    - 1. Patient
    - 2. Family
    - 3. Friends
    - 4. Police
    - 5. Others
  - E. Reliability
    - Variable
      - a. Memory
      - b. Trust
      - c. Motivation
      - Made at the end of the evaluation, not the beginning
  - F. Chief complaint
    - 1. Main part of the health history
    - 2. The one or more symptoms for which the patient is seeking medical care for
  - G. Present illness
    - 1. Identifies chief complaint
    - 2. Provides a full, clear, chronological account of the symptoms
  - H. Past history
    - 1. General state of health
    - 2. Childhood illnesses
    - 3. Adult illnesses
    - 4. Psychiatric illnesses
    - 5. Accidents and injuries
    - 6. Operations
    - 7. Hospitalizations

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- Current health status
  - 1. Focuses on present state of health
  - 2. Environmental conditions
  - 3. Personal habits
    - a. Current medications
    - b. Allergies
    - c. Tobacco use
    - d. Alcohol, drugs and related substances
    - e. Die
    - f. Screening tests
    - g. Immunizations
    - h. Sleep patterns
    - i. Exercise and leisure activities
    - i. Environmental hazards
    - k. Use of safety measures
    - I. Family history
    - m. Home situation and significant other
    - n. Daily life
    - o. Important experiences
    - p. Religious beliefs
    - q. Patients outlook
- J. Review of body systems
- III. Techniques of history taking
  - A. Setting the stage
    - 1. Reviewing the medical history
      - a. Briefly review any previous medical records available
      - b. Important insight
        - (1) Referral
        - (2) Life experience
        - (3) Past diagnosis and treatment
    - 2. The environment
      - a. Proper environment enhances communication
      - b. Place for you and the patient to sit
      - c. Be cautious of power relationship
      - d. Personal space
    - 3. Your demeanor and appearance
      - a. Just as you are watching the patient, the patient will be watching you
      - b. Messages of body language
      - c. Clean, neat, professional appearance
    - Note taking
      - a. Difficult to remember all details
      - b. Most patients are comfortable with note taking
        - (1) If concerns arise, explain your purpose
        - (2) Do not divert your attention from the patient to take notes
  - B. Learning about the present illness
    - 1. Greeting the patient
      - a. Greet by name
      - b. Shake hands

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- c. Avoid the use of unfamiliar or demeaning terms such as Granny or Hon, etc.
- 2. The patient's comfort
  - a. Be alert to patient comfort levels
  - b. Inquire about the patient's feelings
  - c. Watch for signs of uneasiness
- 3. Opening questions
  - a. Find out why the patient is seeking medical care or advice
  - b. Use a general, open-ended question
  - c. Follow the patient's leads
    - (1) Facilitation
      - (a) Your posture, actions or words should encourage the patient to say more
      - (b) Making eye contact or saying phrases such as "Go-on" or "I'm listening" may help the patient to continue
    - (2) Reflection
      - (a) Repetition of the patient's words that encourage additional responses
      - (b) Typically does not bias the story or interrupt the patient's train of thought
    - (3) Clarification
      - (a) Used to clarify ambiguous statements or words
    - (4) Empathetic responses
      - (a) Use techniques of therapeutic communication to interpret feelings and your response
    - (5) Confrontation
      - (a) Some issues or response may require you to confront patients about their feelings
    - (6) Interpretation
      - (a) Goes beyond confrontation, requires you to make an inference
    - (7) Asking about feelings
- 4. Getting more information
  - a. Attributes of a symptom
    - (1) Location
      - (a) Where is it
      - (b) Does it radiate
    - (2) Quality
      - (a) What is it like
    - (3) Quantity or severity
      - (a) How bad is it
      - (b) Attempt to quantify the pain
        - ) 1 10 scale
        - ii) Other scales
    - (4) Timing
      - (a) When did it start
      - (b) How long does it last
    - (5) The setting in which it occurs
      - (a) Emotional response
      - (b) Environmental factors
    - (6) Factors that make it better or worse

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#### (7) Associated manifestations

- C. Clinical reasoning
  - Results of questioning may allow you to think about associated problems and body systems
- D. Direct questions
  - 1. To gather additional information, direct questions may be required
  - 2. Should not be leading questions
  - 3. Ask one question at a time
  - 4. Use language that is appropriate
- E. Taking a history on sensitive topics
  - 1. Alcohol and drugs
  - 2. Physical abuse or violence
  - 3. Sexual history

# IV. Special challenges

- A. Silence
  - 1. Silence is often uncomfortable
  - 2. Silence has meaning and many uses
    - a. Patients may use this to collect their thoughts, remember details or decide whether or not they trust you
    - b. Be alert for nonverbal clues of distress
    - Silence may be a result of the interviewer's lack of sensitivity
- B. Overly talkative patients
  - 1. Faced with a limited amount of time interviewers may become impatient
  - 2. Although there are no perfect solutions, several techniques may be helpful
    - a. Lower your goals, accept a less comprehensive history
    - b. Give the patient free reign for the first several minutes
    - c. Summarize frequently
- C. Patients with multiple symptoms
- D. Anxious patients
  - 1. Anxiety is natural
  - 2. Be sensitive to nonverbal clues
- E. Reassurance
  - 1. It is tempting to be overly reassuring
  - 2. Premature reassurance blocks communication
- F. Anger and hostility
  - 1. Understand that anger and hostility are natural
  - 2. Often the anger is displaced toward the clinician
  - 3. Do not get angry in return
- G. Intoxication
  - 1. Be accepting not challenging
  - 2. Do not attempt to have the patient lower their voice or stop cursing; this may aggravate them
  - 3. Avoid trapping them in small areas
- H. Crying
  - 1. Crying, like anger and hostility may provide valuable insight
  - 2. Be sympathetic
- I. Depression
  - 1. Be alert for signs of depression

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- 2. Be sure you know how bad it is
- J. Sexually attractive or seductive patients
  - 1. Clinicians and patients may be sexually attracted to each other
  - 2. Accept these as normal feelings, but prevent them from affecting your behavior
  - 3. If a patient becomes seductive or makes sexual advances, frankly but firmly make clear that your relationship is professional not personal
- K. Confusing behaviors or histories
  - Be prepared for the confusion and frustration of varying behaviors and histories
  - 2. Be alert for mental illness, delirium or dementia
- L. Limited intelligence
  - 1. Do not overlook the ability of these patients to provide you with adequate information
  - 2. Be alert for omissions
  - 3. Severe mental retardation may require you to get information from family or friends
- M. Language barriers
  - 1. Take every possible step to find a translator
  - 2. A few broken words are not an acceptable substitute
- N. Hearing problems
  - 1. Very similar to patients with a language barrier
  - 2. If the patient can sign, make every effort to find a translator
- O. Blind patients
  - Be careful to announce yourself and to explain who you are and why you are there
- P. Talking with family and friends
  - 1. Some patients may not be able to provide you with all information
  - 2. Try to find a third party who can help you get the whole story